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WASHINGTON, D.C. UPDATE ON HOUSE BUDGET COMMITTEE'S FEDERAL FISCAL YEAR 2012 BUDGET RESOLUTION

On April 5, 2011, the House Budget Committee approved a draft Federal Fiscal Year (FFY) 2012 Budget Resolution on a 22 to 16 vote along party lines. This budget resolution would reduce estimated net Federal spending by $4.3 trillion over the next ten years, not counting interest savings and assumed savings from the reduced Iraq and Afghanistan war-related spending. The spending reductions would be far greater in future decades, in part, because it would establish a binding cap on total spending as a percentage of gross domestic product (GDP). The House Budget Committee is chaired by Representative Paul Ryan (R-WI), which explains why the budget plan sometimes is called "Ryan's budget plan" in news reports.

Under the Congressional budget process, the purpose of the annual budget resolution is to set non-binding spending and revenue targets to guide Congressional action on fiscal legislation, including appropriations and tax legislation. Adoption of the budget resolution requires joint approval by both houses, but not the President. Congress did not approve a FFY 2011 budget resolution even though the Democrats controlled both houses last year. In fact, the Senate never passed its version of the FFY 2011 budget resolution. Even if a FFY 2012 budget resolution is adopted this year, Congress separately would have to enact legislation in order for its spending reductions to take effect. The Republican-controlled House is expected to approve the FFY 2012 budget

resolution along party lines later this week. It is far less certain whether an agreement between both houses can be reached on a FFY 2012 budget resolution.

Major provisions of County interest in the FFY 2012 budget resolution, as passed by the House Budget Committee, include the following:

- **Reduces Medicaid spending by $1.4 trillion over the next ten years by replacing the current open-ended Medicaid entitlement in FFY 2013 with a block grant in which Federal funding to states is capped ($771 billion savings) and repealing the Medicaid coverage expansions ($627 billion savings) in the health care reform law [Affordable Care Act (ACA)];**

- Reduces an additional $776 billion in Federal mandatory (entitlement) spending over ten years by repealing other ACA provisions, including its health insurance subsidies;

- Reduces overall non-security discretionary spending in FFY 2012 by $72 billion below the FFY 2010 level and reduces such spending by over $1.6 trillion over the next ten years through FFY 2021;

- Reduces Medicare spending by $30 billion over the next ten years by increasingly larger amounts beginning in 2022 when Medicare would be converted to a system of premium support payments to help beneficiaries buy private insurance and when its age eligibility would gradually increase by two months per year until it reaches age 67 in 2033;

- Reduces mandatory (entitlement) spending other than Medicaid, health care reform, Medicare, and Social Security by a total of $715 billion over the next ten years;

- Converts the Supplemental Nutrition Assistance Program (SNAP), which was formerly called Food Stamps, from an open-ended entitlement for needy individuals into a state block grant, which would have time limits and work participation requirements for participants;

- Establishes a binding cap on total spending as a percentage of GDP, which is likely to result in deep spending reductions in future decades; and

- Enforces the proposed spending limits/reductions by requiring any increase in the statutory Federal debt limit to be accompanied by the enactment of enforcement mechanisms to ensure that the spending reductions are met.

> If such spending reductions are not enacted, then an across-the-board spending reduction with an exemption for Social Security would be applied at the year.

It is noteworthy that the current statutory Federal debt limit is expected to be reached in the middle of May 2011. The proposal to require that any increase in the statutory debt limit to be accompanied by budget enforcement mechanisms indicates that Congressional Republicans plan to use the upcoming debt ceiling legislation as the legislative vehicle strategy for securing mandatory spending reductions and budget reforms. The debt ceiling increase legislation is considered to be "must-sign" legislation because, without an increase in the debt ceiling, the Federal government would default on its debt obligations -- a default which would have enormously negative economic repercussions. The Federal government currently can borrow at extremely low interest rates because its bonds and notes are viewed as being extremely safe. Its borrowing costs would increase dramatically if Federal debt were perceived as being more risky.

A detailed analysis of the fiscal impact on the County of the House Budget Committee's FFY 2012 Budget Resolution is not possible at this time because it lacks details on how most of its proposed spending reductions would be met. For example, it does not include proposed funding levels for individual discretionary programs, such as the State Criminal Alien Assistance Program, Workforce Investment Act, Section 8 Housing, Community Development Block Grant, and Ryan White AIDS programs, which later will be set under annual appropriations bills. It also does not explain how the $715 billion in mandatory spending reductions in entitlement programs, excluding Medicaid, Medicare, Social Security, and health care reform spending, would be achieved. There are numerous other mandatory spending programs, including Title IV-E Foster Care and Adoption Assistance, Temporary Assistance for Needy Families, SNAP/Food Stamps, and Child Support Enforcement, and which are important revenue sources for the County.

This memorandum will focus on an analysis of its Medicaid proposal, which was far more detailed than its other proposals that could potentially affect the County, and which clearly would have the greatest fiscal impacts, by far, on the County of any of its proposals.

Medicaid

The House Budget Committee's FFY 2012 Budget Resolution would reduce overall Medicaid spending over the next ten years by $1.4 trillion below the Congressional Budget Office's (CBO) current law baseline estimate by repealing the Affordable Care Act's Medicaid coverage expansions ($627 billion savings) and by replacing the current open-ended Medicaid entitlement in FFY 2013 with a block grant in which Federal

funding to states is capped ($771 billion savings). Under the proposed Medicaid block grant, annual funding would be indexed for changes in population and the Consumer Price Index for Urban Consumers (CPI-U). States also would be provided greater flexibility over program design.

The House Budget Committee did not include a detailed description of its Medicaid block grant proposal. Therefore, it is unclear exactly which Medicaid provisions in the ACA and the rest of current law would be repealed and how they would be replaced by new block grant requirements, such as those relating to financing, eligibility and covered services. The extent of flexibility provided to states would greatly affect the impact of the Medicaid block grant on the County -- not only on the County's Federal and State revenue, but also on Net County Costs (NCC) and services. For example, if the State is allowed to reduce Medicaid/Medi-Cal eligibility and eliminate Disproportionate Share Hospital (DSH) funding, then the County's revenue would drop while our unreimbursed costs would increase.

Given the lack of details on the House Budget Committee's block grant proposal, its fiscal impact on the County cannot be precisely estimated. **However, it is certain that the Medicaid spending levels envisioned by the Committee would result in a significant reduction in Federal Medicaid funding for California and the County that cannot be absorbed with major reductions in Medicaid eligibility, covered services, and/or payments to providers.** Based on the description of the proposal provided by Committee staff, the CBO estimates that it would reduce Federal Medicaid spending by 35% below the amount that would be spent in 2022 under current law and by 49% by 2030. This is largely because the proposed Medicaid block grant funding would be limited to increases for population and inflation (CPI-U) -- increases which would be far less than the growth in Medicaid financing needs.

If such a block grant had been in effect in 2000, Federal Medicaid spending would have grown by 36.35% (9.70% for population growth and 26.65% for CPI-U growth) between FFYs 2000 and 2010. In comparison, Federal Medicaid spending grew by 97.50% from FFYs 2000 to 2010, even excluding the impact of the temporary FMAP increase. The block grant would have resulted in states receiving roughly $72 billion (32%) less Medicaid funding in FFY 2010 than they actually receiving, even not counting the roughly $40 billion increase from the FMAP increase. Moreover, during the same ten-year period, the number of Medicaid recipients and medical care component of the CPI grew by 58.50% and 48.94%, respectively. In other words, the Medicaid caseload and medical inflation, which more accurately measure Medicaid financing needs, grew by a combined 107.44% -- nearly triple the 36.35% growth in the population and CPI-U. Over the next ten years, it is expected that the total U.S. population will continue to grow

at an annual rate of 1% or less, and that the CPI-U also will grow at a far lower rate than CPI-medical inflation.

Basing annual Federal Medicaid block grant funding levels on population also is problematic because of the difficulty of accurately counting population, especially for individual states. In fact, the margin of error in annual population estimates and the decennial census is well over 1% -- the current annual growth rate for the total U.S. population. Under the proposed block grant, every person not counted in official Federal population estimates would mean significantly less Medicaid funding for states. Based on Centers for Medicare and Medicaid Services expenditure data and 2010 census data, California received $742 in Federal Medicaid funding per capita in FFY 2010, compared to $868 per capita for the nation as a whole. Moreover, the annual per capita loss in Medicaid funding from undercounting population will grow over time because annual Medicaid funding will be increased for growth in the CPI-U. For example, if the CPI-U were to grow at the same rate as it did between 2000 and 2010, the Medicaid funding loss per capita from population undercounts would be 26.65% higher after ten years.

The potential loss of Federal Medicaid funding due to the undercounting of population could be sizable -- especially for California, the nation's most populous state. California's Department of Finance estimates that the State's population was 38,826,898 in July 2010, which is 1,372,942 more than the 37,253,956 counted in the decennial 2010 census. A future population undercount of such magnitude would cost California more than $1 billion in annual Medicaid block funding (1,372,942 times $742), even not adjusting for future CPI increases.

California would be especially hurt by the block granting of Medicaid because the State receives far less Federal Medicaid funding per recipient than any other state. In FFY 2007, California received only $1,584 in Federal Medicaid payments per recipient, which was less than half of the $3,194 Federal payment per recipient received by the median state. As a result, California's initial base block grant funding would be extremely low relative to all other states. This means that California would be unable to absorb major Federal Medicaid revenue losses without using its increased flexibility under the block grant to reduce Medicaid/Medi-Cal eligibility, payments to providers, the scope of covered services, and/or shift a greater share of non-Federal costs to counties – all of which would hurt the County and its residents.

Medicaid, by far, is the single largest and most important single source of Federal and State revenue to the County. It is the primary financing source for health and mental health services provided to indigent and uninsured residents by the County's Departments of Health Services (DHS) and Mental Health (DMH) and for Medicaid

eligibility determination and In-Home Supportive Services (IHSS) administered by the Department of Public Social Services (DPSS). In 2011-12, the County should receive over $3.1 billion in Federal Medicaid revenue, including an estimated $1.4 billion for the DHS and $440 million for the DMH. Another $1.2 billion reimburses DPSS Medicaid and IHSS administrative costs and finances the Federal Medicaid share of IHSS provider payment costs.

The proposed Medicaid block grant also could lead to major increased NCC resulting from reductions in Medicaid eligibility because the County would be responsible for financing health care provided to indigent persons no longer eligible for Medicaid, pursuant to Section 17000 of the Welfare and Institutions Code. Moreover, the risk of reduced Medicaid eligibility and/or enrollment caps would be especially great during economic downturns when the need for Medicaid grows while State revenues drop. For example, Medicaid enrollment in California grew by 617,000 (9.44%) from June 2008 to June 2010 due to the recession and the State being prohibited from reducing Medicaid eligibility as a condition for receipt of the temporary FMAP increase under the American Recovery and Reinvestment Act. It is hard to imagine that the State would allow Medicaid enrollment to grow so much in the future if the open-ended Medicaid entitlement were replaced with a block grant, which would be capped at lower funding levels.

The County's DHS would incur even greater uncompensated care costs if the State also were to reduce Medicaid provider payments, including DSH payments which currently help finance uncompensated care provided by safety net hospitals, including DHS hospitals. If Medicaid is converted into a block grant, it is highly unlikely that states would be required to continue to use their reduced Federal Medicaid block grant funding to make DSH payments, especially when most states currently receive relatively little Federal DSH funding. While California currently receives roughly $1.1 billion in annual DSH funding, most states receive less than $100 million. Moreover, state Medicaid DSH allotments nationally were reduced by a combined total of $18.1 billion in FFYs 2014 through 2020 under the health care reform law.

Reduced Medicaid provider payments and eligibility also could threaten the entire Countywide emergency medical care and trauma care system. Under Federal law, hospital emergency rooms are required to provide emergency care to all patients without ability to pay. If available Medicaid revenue significantly decreases, then more private hospitals are likely to close their emergency rooms to protect against higher uncompensated care costs, which, in turn, can lead to a domino effect of more and more emergency room closings. This, in turn, shifts even greater operational and financial burdens on County DHS hospitals. Moreover, the closing of hospital emergency rooms would endanger the health and lives of all County residents and

visitors, not limited to Medicaid recipients.

The proposed Medicaid block grant could greatly increase the County's share of costs for not only health services, but also IHSS and mental health services. This is because the County's share of IHSS and mental health costs, as well as health costs, will increase to the extent that the State uses its block grant flexibility to use a greater share of available Federal Medicaid revenue to reduce State General Fund costs. The potential risk of increased NCC is especially high for IHSS for which counties are financially responsible for 35% of non-Federal costs and community mental health services for which counties are wholly responsible under the 1991 State realignment law.

IHSS costs have been growing at a far faster rate than other Medicaid costs. We currently estimate that, in the upcoming 2011-12 fiscal year, Federal Medicaid revenue will reimburse nearly $1 billion in IHSS costs, including IHSS provider payments made directly by the State. Based on current statutory cost-sharing ratios, the County would incur $35 million in increased NCC for IHSS for every $100 million in Federal Medicaid block grant funding that the State, instead, uses to reimburse nursing home costs for which the State finances 100% of non-Federal costs. The net State General Fund cost savings would be even greater for every Federal dollar not spent on community mental health services.

In closing, it is noteworthy that the ACA includes two important protections for counties from a shift in costs to counties that are at risk if ACA is repealed and Medicaid is converted into a state block grant. That is, as a condition for receipt of the higher FMAP for the cost of medical assistance provided to newly eligible Medicaid beneficiaries in 2014, states are prohibited from either increasing local governments' percentage share of non-Federal Medicaid costs or reducing Medicaid eligibility.

We will continue to keep you advised.

WTF:RA
MR:MT:sb

c: All Department Heads
Legislative Strategist